



MedicareBlueSM PPO

A Medicare Advantage Plan

Medical Management
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P.O. Box 64265, Route R4-18 • St. Paul, MN 55164-0560

PRIOR AUTHORIZATION REQUEST

(Please complete all applicable information)

Provider: _____	Subscriber: _____
Provider Number: _____	Address: _____
Address: _____	_____
_____	_____
Zip: _____	Phone: _____
Phone: _____	Group #: _____
Fax: _____	Identification #: _____
Contact: _____	

PATIENT INFORMATION

Case ID Number: _____ (assigned by MedicareBlue PPO)

Patient: _____

Birth Date: _____

Specific Procedure Planned: _____

Diagnosis – ICD-9 Code: _____

CPT-4 Code(s) to be used: _____

Please attach relevant medical documentation: _____

Signature of Provider

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